Government and Medicine

Considerations in Devising an Overall Health Plan

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EDITOR'S NOTE: *This report was prepared by Dr. Roth and submitted to the Department of Health, Education, and Welfare. It was transmitted to the House of Delegates in November 1970 for their information. It is presented here in the belief that it will be of great interest to the readers of* CALIFORNIA MEDICINE.

Thesis:

The principal resource for meeting the medical service needs of the Nation is the existing supply of practicing physicians.

1st priority is for using effectively those practicing physicians we now have.

2nd priority is to do those things which may be done to increase the productivity of physicians.

3rd priority is to augment the number of physicians.

4th priority is to use the physician effectively in his role as a conservator of expenditures by and in behalf of his patients.

Considerations in respect to the 1st priority (effective use):

There has been a substantial "flight from practice," and especially from general practice, which has intensified our problems in the delivery of medical service. The factors which have caused this exodus from direct patient care should be recognized and, to the extent possible, eliminated. There has also been the disturbing fact that although new physicians are being trained at a rate well exceeding the rate of general population growth, these young doctors are not being motivated to enter into direct patient care in the areas of greatest need. If we wish to hold on to our current supplies of active practitioners and to increase them in a rational fashion there are certain things that we should do, and a number of things which we assuredly should not do.

1—In the existing climate of the United States, efforts to regiment, conscript, or apply economic sanctions to the medical profession are destined to make matters worse rather than better. They have the effect of driving even more physicians from active practice into research, teaching, administrative medicine, more narrow specialization or premature retirement.

2—Promises on the part of government that practicing physicians will deliver even more health service to beneficiaries than they are now able to produce under stress conditions force still more physicians to seek refuge from the pressures.

3—The practicing physician is confronted with increasing costs of living and of doing business. In a generally uncontrolled economy, measures which would freeze the income levels of physicians, eliminating their ability to adjust to the economic environment are discriminatory and lead to still further departures from active practice.

4—The individual physician has limited opportunity or capacity to respond to over-all societal demands. These responses are best made by physicians collectively, acting in concert through their professional associations. It is in the best interests of the Nation that professional organizations be aided and abetted in their co-

operative efforts. To denigrate them and to give them adverse tax treatment reduces their capacities and their resources for constructive input.

5—It has been proposed in several legislative bills that bonus dollars will motivate physicians to establish practices in rural and urban shortage areas. The fact is that large numbers of physicians who have been providing service in those areas leave lucrative practices for less rewarding circumstances in which the offsets are such things as personal and family security, improved educational facilities, or a lessened pressure of patient demand.

6—Prepaid comprehensive group practice has been "discovered" as a potential answer to most of the delivery problems. Rechristened "Health Maintenance Organizations," these arrangements for practice are offered as a panacea without recognition of the fact that such groups have been encountering serious problems of their own, that many patients do not wish to enroll in such plans, and that many physicians have no interest in practicing in them. The many variations of this approach deserve support as competitive mechanisms with a chance to prove such superiorities as they may develop in respect to quality, efficiency and economy; but to attempt to force all physicians into a rigid pattern of salaried group practice could be the most destructive move made by government.

7—Plans which would base the entire delivery system of medical service upon "primary physicians" with responsibility for channelling patients and regulating payments to consultants, specialists and the like betray a lack of understanding as to how medicine is practiced.

8—The willingness of physicians to participate in and to be subject to peer review in respect to the quality and quantity of their services and the charges made therefor are encouraging. This should be supported, not discounted. The prospect of evaluation by non-medical reviewers, or medical reviewers hired by non-medical agencies is a strong deterrent to cooperation.

In summary, to keep physicians in active practice, rather than to disperse them, government should abandon emphasis on prepaid comprehensive group practice although it may still support it. It should uphold the principle that a physician should be expected to charge his usual fees to all patients and should depend on a strengthened system of peer review to guarantee that such usual fees will conform with customary fees and be kept within the ranges of what can be defined as "reasonable." Mathematical formulae for freezes and arbitrary percentiles should be abandoned. It should probably be accepted that highly trained physicians cannot be attracted into practice in rural areas or in many slum areas, and alternative mechanisms for the provision of adequate medical service should be developed.

Considerations in respect to the 2nd priority (increased productivity):

1—There is, in general, little opportunity to increase the productivity of the average practicing physician by simple extensions of his working hours. Actually current enthusiasm for group practice formulae seem to be retrogressive inasmuch as it is represented to the physician who is currently working 60-70 hours per week that under group practice arrangements he may reduce this to 50 or less hours per week. Scattered figures may be cited to support the idea that 100 physicians in solo practice actually provide service to more patients per week than do 100 physicians in group practice of any type.

2—The multiple experimental programs of Medex, Duke University, the American Urological Association, and scores of others to develop support to the practicing physician deserve subsidy and assistance. At the same time serious attention must be paid to the medical practice acts of the several states, to factors of professional liability, insurance coverage, and the like.

3—Restrictive provisions in such programs as Medicare and Medicaid which make it economically unfeasible for physicians to delegate to others—especially to interns, residents and office assistants—the provision of appropriate services should be eliminated or readjusted.

4—Government has taken an unproductive and adverse position in respect to those physicians who have appeared to earn "too much" money from Federal and State programs. Instead of the antagonistic approach of questioning the financial "take" by such persons focus should be on requesting "peer review" of the quality of care offered by these mass producers. It may be good.

5—Many physicians are dissuaded from, or become disenchanted with, efforts to provide medical service for Federal and State program beneficiaries because of relatively low compensation, excessive paper work, and an exposure to adverse publicity because of payments

received. This should be corrected. Physicians willing to devote themselves to this type of work in volume should be praised rather than denigrated for their efforts.

Consideration in respect to the 3rd priority (augmentation of physician numbers):

1—Support to the educational roles of medical schools should be clearly separated from support to medical research so that the latter is not used as a subterfuge for the building of a medical school faculty, or the underwriting of medical school operations.

2—As much attention should be devoted to keeping in clinical practice the physicians we have, as [is devoted] to the training of more physicians.

3—A positive program of public relations dedicated to making the clinical practice of medicine attractive to oncoming generations of young Americans would be more productive than a campaign to picture physicians as entrepreneurs requiring regimentation and control.

4—Serious attention should be given to the problem of professional liability insurance and the jeopardy in which the practicing physician finds himself today. It is no small matter that the new physician finds that he must pay from two to ten thousand dollars per year in malpractice insurance premiums before he feels safe to treat his first patient. It is equally important to recognize that many active practitioners are being forced from practice by the inability to purchase at any reasonable figure adequate liability insurance. The answer does not lie in finding new "carriers" for the insurance. It lies in legal reforms governing liability.

Considerations in respect to the 4th priority (conservator of public expenditures):

1—"Peer Review" is the governing concept which requires support. To dilute it with lip service to consumer representation is not helpful. The medical profession needs to be supported in the outstanding progress which it has made in the past decade in the perfection of peer review techniques.

2—Indoctrination in peer review should be looked upon as a proper role of National, State and County Medical Societies for incorporation into medical school curricula and hospital intern and residency training programs.

3—Techniques of education for the practicing physician in the relationship between hospitalization, physician orders and prescribing practices and the expenditures mandated for patients or those who pay their bills should be advanced.

4—Considerable attention should be given to the thought that when a physician is salaried, or otherwise divorced from the fee-for-service method of compensation, he is insulated from a specific interest in how his services or his authorizations for service have impact upon the economics of medical care.

TESTING FOR SENSORY PARESIS WITH VOCAL CORD PARALYSIS

"For a long time I never tested for sensory paresis or paralysis when I saw a patient with a paralyzed vocal cord. But a simple test is to dress a curved laryngeal applicator with cotton and test the sensation of the epiglottis, the aryepiglottic folds, and the false and true cords. . . . Care must be taken not to touch the base of the tongue during this procedure since we want to test primarily the tenth nerve and not the ninth. We test first one side and then the other; and we will find not only unilateral but sometimes bilateral lesions."

—DAVID W. BREWER, M.D., Syracuse

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